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ABSTRACT

This annual report of the Long-Term Care Ombudsmen Program of the Oklahoma Department of Human Services begins by stating the purpose of the program: to improve the quality of life and the quality of care of older residents of long-term care facilities in Oklahoma. It is noted that the Long-Term Care Ombudsman advocates for the rights of long-term care facility residents and acts as an objective mediator in problem situations, and that the State Ombudsman Program investigates and resolves complaints made by or for older individuals who reside in long-term care facilities; bridges between older residents of long-term care facilities and the aging network; and monitors the development and implementation of federal, state, and local laws, regulations, and policies that relate to long-term care facilities in the state. This report describes statewide Ombudsman Program activities during fiscal year 1990, including volunteer recruitment, screening, and training, and consumer education. It also describes the complaint documentation system, discusses facilities with multiple complaints, and examines guardianships and other surrogate decision-making. A program funding report, list of types of long-term care facilities, an adverse action list, and relevant graphs are appended. (NB)

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State of Oklahoma
Department of Human Services

Long-Term Care Ombudsman Program

Annual Report

Oct. 1, 1989 through Sept. 30, 1990

OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN
AGING SERVICES DIVISION

C6023675

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FY 1990
LONG-TERM CARE OMBUDSMAN ANNUAL REPORT

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OKLAHOMA
LONG-TERM CARE OMBUDSMAN PROGRAM
ANNUAL REPORT
FEDERAL FISCAL YEAR 1990
(October 1, 1989 - September 30, 1990)

I. PROGRAM PURPOSE AND DEFINITIONS

The purpose of the Ombudsman Program, mandated by the Older Americans Act, is to improve the quality of life and the quality of care of older residents of long-term care facilities in Oklahoma. These facilities include nursing homes and residential care facilities. "Older residents" are people sixty years of age and older who live in long-term care facilities. Residents younger than 60 may be served by the Ombudsman Program, if they have no other means of advocacy available and if such services do not diminish the program's ability to serve older residents.

The concept of the Ombudsman Program originated in Sweden during the 18th century. There, the ombudsman functioned as an impartial mediator between citizens and the government by providing information, mediating disputes, and attempting to resolve complaints. In much the same way, the Long-Term Care Ombudsman advocates for the rights of long-term care facility residents, and acts as an objective mediator in problem situations.

The Older Americans Act delegates to the State Ombudsman Program the responsibility to investigate and resolve complaints made by or for older individuals who reside in long-term care facilities. This may include action or inaction of long-term care service providers, or of public or service agencies, which may adversely affect the health, welfare, or rights of these residents.

Included as a major program component is the capacity for intake, investigation, resolution or referral, and follow-up of complaints received through the program's complaint mechanism, which is described elsewhere in this report. Prevention of problems which may lead to complaints is addressed by Ombudsmen through regular visitation and in-service education. Ombudsman Volunteers and Ombudsman staff at the Area Agencies on Aging provide the majority of this personal advocacy for long-term care facility residents.

Another function of Oklahoma's Ombudsman Program is bridging between older residents of long-term care facilities and the aging network, including the Area Agencies on Aging and their grantees. Interaction among the community, long-term care

facility residents, and facility staff is of concern to the Ombudsman Program, since this can have considerable impact on the residents' quality of life. In addition, the resident may have service needs which only community-based agencies or organizations can meet. Access to these services is being addressed by the local Ombudsman Volunteer Program, as well as the State staff.

A third federally required activity for the Program is to "monitor the development and implementation of Federal, State and local laws, regulations and policies that relate to long-term care facilities in the State." Oklahoma's Nursing Home Care Act and the Residential Care Act require each agency or department conducting inspections, surveys, or complaint investigations in nursing homes and residential care homes to forward copies of their reports to the State Ombudsman. These mandates provide a basis for interaction between Ombudsmen and the State's regulatory agencies.

Consumer education is a program priority to bring about informed use of long-term care services and the systems available to protect the consumer. Another mandated activity is provision of information to the public and to public agencies about the problems of older persons in long-term care facilities. This is addressed as an on-going responsibility, as well as being the basis of this report.

II. STATEWIDE OMBUDSMAN PROGRAM ACTIVITIES DURING FY 1990

Office of the State Long-Term Care Ombudsman

During FFY 1990, the Oklahoma Office of the State Long-Term Care Ombudsman, like virtually every other group or program involved with nursing homes, carried out an array of activities to prepare for the October 1, 1990, implementation date of the 1987 federal nursing home reform law (OBRA 1987). Updates from the national level, including amendments to OBRA, were passed on to area Ombudsman staff and volunteers. Information was exchanged with enforcement and industry representatives, and shared with consumers. State staff also held a training retreat for area Ombudsman staff, for intensive review of the federal law and regulations, immediately before full implementation took effect.

Shortly before October 1, 1990, Ombudsmen also conducted a statewide survey of nursing homes to assess their "readiness" related to new licensed nurse staffing requirements. The information gathered from this study was forwarded to the Oklahoma Congressional delegation in an attempt to prevent adoption of a proposed amendment to the nurse waiver provisions of the law.

Also during FY 1990, State staff continued to work on remedies for the Medication coverage issues raised in the FY 89 Annual Report. Meetings were held with DHS Medical Services Division staff and others to assess the extent of problems and to consider strategies to address them. Legislative action (during the 1990 session) to expand the Medicaid drug formulary has resolved the majority of drug coverage complaints which Ombudsmen had been hearing.

The Office completed the process of revising the policies of the Program, to comply with new provisions of the Older Americans Act and to implement the Oklahoma Long-Term Care Ombudsman Act (enacted in 1989). Comments were received from many entities throughout the aging network, including consumers, local ombudsmen, sponsoring agencies, and long-term care providers. A public hearing was held before final adoption of the proposed rules. The rules became effective in September, 1990.

The new policies of the Office include sections on identifying and preventing conflicts of interest within the Ombudsman program, expanded requirements for safeguarding confidential information, and curriculum outlines for mandatory training of program staff and volunteers.

During the reporting period, new Ombudsman Supervisors joined the program in four Area Agencies on Aging, and were trained by State Ombudsman staff. In support of these new staff, State staff also conducted volunteer trainings in three local areas.

Oklahoma Ombudsman staff were able to participate in national-level activities in various ways during the reporting period. Two of these were of particular benefit to the program. The State Ombudsman served as President of the National Association of State Long-Term Care Ombudsman Programs until May, 1990. She also began in FY90, and continues through the present, to serve on the Advisory Board of the National Resource Center for State Long-Term Care Ombudsman Programs. The Resource Center is funded by the Federal Administration on Aging and has produced a series of technical assistance and resource manuals.

In addition to these activities, State level staff have responded to over 540 requests for information about nursing home and residential care services, the services of the Ombudsman Program, issues affecting institutionalized elders, and other types of non-complaint requests from the public. (Direct complaint involvement is described in Section III.) State Staff also worked with various advocacy groups, agencies, and committees, including the State Council on Aging and the Long-term Care Ombudsman Program Advisory Committee.

State staff provide direct program supervision and continuing education for local Ombudsman Supervisors. In addition, State staff provided complaint response and volunteer supervision, for portions of the reporting period, in parts of the State where illness or other extended absence of local staff made it necessary.

Local Ombudsman Program Staff and Volunteers

At the local level, much of the work of the program is accomplished by certified Volunteers. During the reporting period, 236 volunteers provided 21,791 hours of service to people living in nursing homes or residential care homes. Applying a conservative dollar value ($5.00 per hour), these volunteers contributed $108,952 in advocacy assistance. Moreover, the Ombudsman Volunteer provides friendship, support, and reassurance which cannot be measured adequately in monetary terms.

In addition to the Volunteers' visits, thirteen Ombudsman Supervisors worked full time in Oklahoma's eleven Area Agencies on Aging, providing services to the residents of every long-term care facility in the State. They address problems and complaints in nursing homes and residential care facilities. Unannounced visits are also made by the Supervisors to become familiar with facilities, residents, and administrators, and to provide them with information about the Ombudsman Program.

Ombudsman Supervisors and Volunteers also participate as citizen observers on inspections conducted by the State Health Department. This role, provided for by Oklahoma's Nursing Home Care Act of 1980, assists the Ombudsman Program to carry out its duty to monitor the implementation and enforcement of federal, state and local laws, regulations and policies. As citizen observers, Ombudsmen also can provide input to the inspectors concerning ongoing problems in facilities visited more frequently by Ombudsmen than by enforcement teams.

When possible, Ombudsman Supervisors participate in Patient On-site Reviews (now called Care Assurance Validation) conducted by the Non-Technical Medical Care nurses of the Department of Human Services.

The AAA Ombudsman Supervisors' duties include:

1) complaint investigation and resolution, or referral;

2) recruiting, training, screening and supervising Volunteers;

3) publicizing the Program's services, and

4) providing community education about long-term care facility residents' needs and concerns, including in-service training for facility staff.

Technical assistance and continuing education were provided to Supervisors by State staff through quarterly meetings, on-site visits, participation in volunteer monthly meetings, problem consultation, and the distribution of printed materials.

VOLUNTEER RECRUITMENT, SCREENING, AND TRAINING

Volunteer recruitment was an important focus of activity by Supervisors this year. To publicize the program's services, and to recruit volunteers, **254** media releases, including radio and T.V., were made. Presentations to civic groups, voluntary organizations, county and city councils on aging, church groups, professional organizations, and the general public are a continuous recruitment and community education activity of the Supervisors. At least **442** presentations were made this year. (This is an increase of 135 presentations made over last federal fiscal year.)

It is a goal of the Program to have an Ombudsman Volunteer in every long-term care facility in the State. No regulation requires this; the Volunteer program was designed by Oklahoma staff. The Supervisors strive to recruit and certify only those individuals who meet qualification standards, and not to meet a numerical goal.

Ombudsman Volunteer Supervisors screen volunteers by written applications, interviews, and often through the training process, itself. Certification is based on the individual's ability to follow program guidelines and to responsibly assist residents with problem resolution, while maintaining objectivity, confidentiality, and respect for residents' rights. During FY 1990, 200 individuals attended trainings. Eighty-four (84) were certified as Volunteers.

During this fiscal year, forty (40) volunteer trainings were provided by Ombudsman staff. The initial training for Volunteers is an intensive two day orientation to the program, the volunteer's role and responsibilities, the regulatory process, residents' rights and the problem-solving process. Other topics included are communication with disabled persons, the processes of aging, and confidentiality. Further training is provided at monthly meetings.

Volunteers are very effective in providing advocacy services to long-term care facility residents. Most of the State is rural, so locally based volunteers can give more expedient service than program staff in State or area agency offices. As part of the communities in which their assigned facilities operate, the Volunteers have a vested interest and a decided advantage in establishing relations between community resources and facility residents.

Through weekly visitation, the Ombudsman Volunteer is able to become familiar with individuals' needs, strengths and concerns. The volunteers' work ranges from problem-solving and complaint resolution to informal visits, with enough program flexibility so volunteers can use their own talents. Section III, **Complaint Documentation** summarizes the problem-solving activities of the volunteers.

Program volunteers are trained to focus on "quality of life" issues as well as quality of care. Helping residents obtain legal advice, assistance with medicine bills, or other community resources, are examples of services often provided by the Ombudsman. Indirectly these services also benefit the facility, by helping to meet needs which affect the resident's quality of life and level of satisfaction. The following table documents the numbers of "information requests" to which Ombudsman Volunteers and Supervisors responded during FY 90.

TABLE I

Information Requests - Addressed by
Sub-State Ombudsman Program

	Volunteers	Supervisors
Nursing Home Services	414	542
Ombudsman Program Information	843	3,670
Legal Services	117	366
Other Community Services	434	2,119
TOTALS	1,808	6,697

GRAND TOTAL 8,505

Other Ombudsman activities for the period included: arranging transportation for long-time friends residing in separate facilities to visit each other, attending Alzheimers Disease support groups, assisting residents with residents council meetings, teaching classes at area nursing schools on the long-term care ombudsman program and residents rights, attending inspections and open meetings conducted by the State Department of Health, and holding a "Christmas in July" celebration in area nursing homes.

CONSUMER EDUCATION

Consumer education is a priority concern of the Ombudsman Program in Oklahoma, and ranges from personal conferences to media releases and public hearings. Literature is made available to inform people of their rights and to assist them in making choices among long-term care services. **Know Your Rights**, a pamphlet developed by the Ombudsman program, is designed for residents of nursing homes and residential care homes. It explains the rights and protections provided by State law. The Ombudsman program seeks to dispel the notion that elders somehow lose their constitutional rights upon admission to a long-term care facility, or upon loss of health.

Elders and their families contact Ombudsmen volunteers and staff for information on selecting long-term care services. **Nursing Home or Alternative Care in Oklahoma** is a booklet distributed by Ombudsmen which provides a description of the continuum of long-term care services, information on financial considerations, and guidance for comparison of nursing care facilities. Inappropriate institutionalization can often be avoided when alternatives are provided to the consumer, family members, doctors, and social workers. In addition, including the potential nursing home resident in the decision-making process can reduce or eliminate subsequent problems of adjustment and acceptance.

SUMMARY

Through their local activities, Ombudsman staff and volunteers help identify major issues affecting long-term care facility residents. Frequently requested services, commonly heard complaints, and needs unmet by state, community or facility programs are the types of information gleaned from volunteers' reports. This is then shared by the Ombudsman Program with care providers, community services and state agencies, organizations, and regulatory bodies. In this way, problems which may not lend themselves to local solution through personal advocacy may be addressed at a broader, systems level. The volunteer program is a keystone in the range of advocacy activities of the State's Long-Term Care Ombudsman Program. Program staff actively advocate needed changes in the service delivery and enforcement systems to improve quality of life and care for residents of long-term care facilities.

III. COMPLAINT DOCUMENTATION SYSTEM

A. Complaint System

The Ombudsman Program is required by the Older Americans Act to "establish a statewide uniform reporting system to collect and analyze information on complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems."

Receipt of complaints and assistance in their resolution is a major function of both State and local level staff. State staff receive complaints directly from the public as well as from the local Ombudsman programs. Complaints are filed by residents, friends and families of residents, facility staff, hospital staff, doctors, and others who treat or visit residents. If a complaint concerns a facility where an Ombudsman Volunteer works, the volunteer may assist in problem resolution. If a referral to an enforcing agency is needed, it is made by State Ombudsman staff. Ombudsman staff then monitor resolution of the problem.

If a complaint received by Ombudsman staff has already been filed with an enforcement agency, State staff contact the appropriate agency for a status report and follow through from that point. Results are relayed to the Ombudsman Supervisor and volunteer involved so they can compare these results with their own observations. Usually, problems can be resolved without filing a formal complaint with an enforcement program. In all cases, every attempt is made to allow the resident to take part in the resolution and to review the process to assure that the problem is resolved.

Oklahoma's Ombudsman Program also has the responsibility of analyzing reports received from enforcement agencies, in order to identify major problems of long-term care facility residents that could be addressed through regulatory changes or legislation. Oklahoma's Nursing Home Care Act provides that, "All State Agencies receiving complaints on, or conducting surveys or inspections of, nursing home facilities shall forward complete copies of complaints or of inspection or survey results to the Ombudsman Program..." (Title 63 O.S. Section 1-1941). Thus, the Ombudsman staff receive reports from the State Health Department, the Department of Human Services, and the State Board of Nursing Homes (recently renamed the State Board of Examiners for Nursing Home Administrators).

B. Nursing Home Complaints

This section includes a compilation of complaints received by the State Ombudsman Staff, the State Health Department, and by Long-Term Care Investigators of the Special Unit on Aging, Department of Human Services. The following table shows the total numbers of complaints received, action taken, and findings. **These figures represent only those problems filed as formal complaints at the State level of these agencies during the reporting period.**

TABLE II
NURSING HOME COMPLAINTS
(State Level)
OCT. 1, 1989 - SEPT. 30, 1990

	DHS LONG-TERM CARE INVESTIGATORS	STATE HEALTH DEPT.	STATE OMBUDSMAN OFFICE	TOTALS
COMPLAINTS RECEIVED:	379	267	79	725
*VERIFIED OR PARTIALLY VERIFIED:	202	185	52	439
NOT VERIFIED:	177	82	27	286
**REFERRED:	17	0	39	56
FOLLOW-UP VISITS SCHEDULED:	76	68	15	159
PENDING AT END OF YEAR:	70	63	11	144
RESOLVED:	***	***	44	44
CLOSED:	309	204	68	581
NO. OF FACILITIES	127	150	39	****267

* **A single complaint may contain several allegations. The complaint may be totally verified** (all allegations are found to be true), **partially verified,** or **not verified** upon investigation.

** A complaint may be referred to another investigative program before or after initial investigation by the receiving entity, and joint investigations are also possible. **The complaint is listed only once, under the original "recipient."**

*** Not available. Only Ombudsman Program documents this factor, which reflects the complainant's satisfaction with outcome.

**** **This is not a duplicated count.** Many facilities named in complaints are received by DHS, the Ombudsman Program and/or the Health Department. **(See Section IV for a listing of facilities with multiple verified or partially verified complaints.)**

From Table II, the State Health Department verified or partially verified 69% of all complaints it received, State Ombudsman staff verified or partially verified 66%, and DHS Long-Term Care Investigators verified or partially verified 53%. When averaged, these findings indicate that 63%, or close to two-thirds of those persons who filed a formal complaint were found to be justified in doing so. The same standards for analysis were applied to all reports by State Ombudsman staff.

This table does not include problems solved by the local Ombudsman Volunteers and staff, which are reflected in Table IV.

Formal complaints to State Agencies increased significantly (16%) during the report period.

C. Nursing Home Complaint Allegations Described by Category

The Ombudsman Program has a responsibility to identify major concerns affecting older residents of long-term care facilities. Some of the information studied in this process is gleaned from reports of the agencies involved in regulation and complaint investigation.

This section uses categories to describe the allegations included in complaints, regardless of verification, as a means of identifying most frequent complaints. Here, again, 63% of all formal complaints filed at the state level were verified or partially verified.

These statistics are taken from formal complaints received by the State Health Department, by Department of Human Services Long-Term Care Investigators, and the State Ombudsman Program staff, as described in Table II.

TABLE III

NURSING HOME ALLEGATIONS BY SUBJECT CATEGORY

CATEGORY	TOTALS
NURSING CARE	1,449
RESIDENTS RIGHTS	383
FOOD	301
ADMINISTRATIVE	313
HOUSEKEEPING	225
BUILDING	98
FINANCIAL	28
NOT AGAINST FACILITY	12
TOTAL CATEGORIES	2,809

Please refer to Appendix "D" of this report for a graphic presentation of this data.

The categories of allegations listed in the preceding table can also be described in terms of the issues they represent. The following is a brief presentation of some of the issues identified by the Ombudsman Program through analysis of complaint data.

Nursing care, again in FY 1990 as in previous years, was the most frequent subject of complaints received by all agencies. As was discussed in the last two reports, the most serious concern of residents, families, and staff members is that there are not enough direct care staff (nurse aides and orderlies) to meet the increasingly heavy care needs of the population now residing in our nursing facilities. In years past, recommendations have been made to improve the direct care staff to resident ratio in several ways.

This issue still needs to be addressed in State regulation. Aides should be fully counted in the staff-to-resident ratios only after having completed the required training, testing and certification. This would serve residents by having more qualified staff to assist them. The licensure regulation allows direct care staff to include licensed nurses, medication aides, nurses aides, activity and social services or therapy personnel. Since social, therapy, and activity personnel (and often licensed nurses) do not provide direct care, they should not continue to be counted in the ratio. According to complaints, more staff are needed to directly respond to residents. Federal rules require that facilities must employ staff adequate in training and in numbers to meet the needs of the residents. Federal "OBRA" Amendments of 1990 mandated that the Health Care Financing Administration (HCFA) conduct a study of staffing adequacy in nursing homes and determine if a national standard should be set.

Another topic of persistent complaints related to nursing care is that of contagious or infectious diseases. An increased number of complaints include problems related to MRSA (Methycillin-resistant staphylococcus aureus), other staph infections, scabies, skin mites, and AIDS (Acquired Immune Deficiency Syndrome). Infection control is of extreme importance to prevent the spread of these and other conditions. State Health Department Epidemiology Division and nursing home surveyors, Department of Human Services staff, and County Health Departments' staff have investigated and worked together at times to direct and train facilities in proper management of infection control. Nursing facility staff need ongoing training and supervision in this area to reduce fear and protect both staff and residents from contagion. Infection control is something that must be considered routine.

Residents Rights complaints and complaints categorized as "Not Against the Facility" include a variety of problems. The Office continues to receive complaints from residents and friends related to oppressive, unnecessary, and unwanted guardianships. Some of these complaints have been addressed with good results, with residents appearing before judges, being represented by attorneys, and being evaluated through in-patient and out-patient Geriatric Evaluation programs. Guardianships have been reviewed, revised and limited. Some residents have had health care or financial decision-making, voting and other rights restored to them. See ISSUES section for a full discussion of problems associated with guardianships and related concerns.

D. Sub-State Ombudsman Volunteer Program Problem-Solving and Complaint Activity

Ombudsman Volunteers and Area Agency on Aging Ombudsman staff are active in problem-solving within long-term care facilities, and instrumental in the resolution of complaints. The orientation of the Program is towards resolution of problems within a facility whenever possible, encouraging communication of concerns by residents and their representatives to the administration, and providing mediation towards mutually acceptable solutions.

Intervention by the Ombudsman Supervisors at the Area Agencies on Aging, or by the State Ombudsman Staff, occurs when the Ombudsman Volunteer needs assistance or when there is no volunteer for the facility. Referrals to regulatory agencies are made when enforcement authority or special expertise is needed.

Table IV shows problems that have been addressed by the Ombudsman Volunteers and staff with residents, or on the residents' behalf. Note that the types of problems addressed by the Volunteers differ in order of frequency from the complaints filed with State agencies, described in Table III.

TABLE IV

LOCAL OMBUDSMAN PROGRAM PROBLEM-SOLVING/COMPLAINT RESPONSE

	Volunteers	Staff	Total
Nursing Care	1,510	643	2,153
Food	1,692	194	1,886
Resident Rights	550	211	761
Housekeeping	877	104	981
Roommate	404	14	418
Administrative	910	145	1,055
Building and Other	209	96	305
Financial	161	65	226
Discrimination	24	9	33
TOTAL	6,337	1,481	7,818

Of the total number of 6,337 problems addressed by Ombudsman Volunteers during FY 1990, 5,924 problems (or 93%) were resolved by the volunteers working within the facility.

Ombudsman Supervisors located in the eleven Area Agencies on Aging across the state receive complaints from the public and referrals from volunteers and State Ombudsman Staff. In this fiscal year, a total of 642 complaints (which included 1,481 allegations) were received by the Ombudsman Supervisors. Ninety-six percent (or 615) were resolved by them at the local level. Only 4%, or 27 complaints, were referred to the State staff.

The majority of problems and complaints were resolved by communication among the involved parties, or by providing the residents with assistance in solving problems for themselves.

E. Residential Care Facility Complaints

Older residents of Residential Care Facilities are included in the population for Ombudsman Program services.

Table V indicates the number and categories of formal complaints received by the three state level programs on behalf of residents of licensed Residential Care Homes.

TABLE V
RESIDENTIAL CARE HOME FORMAL COMPLAINTS
OCT. 1, 1989 - SEPT. 30, 1990

	DHS LONG-TERM CARE INVESTIGATORS	STATE HEALTH DEPT.	STATE OMBUDSMAN OFFICE	TOTALS
COMPLAINTS RECEIVED:	1	12	6	19
VERIFIED or PARTIALLY VERIFIED:	1	7	2	10
NOT VERIFIED:	0	5	4	9
REFERRED:*	0	0	2	2
FOLLOW-UP VISITS SCHEDULED:	0	0	2	2
PENDING AT END OF YEAR:	1	4	2	7
RESOLVED:	**	**	5	5
CLOSED:	0	8	4	12
NO. OF FACILITIES INVOLVED:	1	12	5	***14

* Complaints may have been referred before or after investigation. These complaints are only counted once.

** Not available

*** **This is an unduplicated count.** Some facilities were named in complaints filed with all three state programs. DHS Long-Term Care Investigators, the State Ombudsman Program and the State Health Department.

From Table V, the State Health Department verified or partially verified **58%**. Ombudsman staff verified or partially verified **33%**, and Department of Human Services Long-Term Care Investigators verified or partially verified **100%**. When averaged, **64%** of formal complaints were found to be justified.

Table VII, lists problems that have been addressed by the Ombudsman volunteers and staff with residents or on residents' behalf. Again note the types of problems addressed by Ombudsman volunteers differ in order of frequency from the formal complaints filed with State agencies.

TABLE VI

RESIDENTIAL CARE HOME COMPLAINTS BY SUBJECT CATEGORY
Oct. 1, 1989 - Sept. 30, 1990

CATEGORY	TOTALS
RESIDENT SERVICES	15
ADMINISTRATION	17
RESIDENTS' RIGHTS	6
FOOD	13
BUILDING	7
HOUSEKEEPING	7
FINANCIAL	1
NOT AGAINST FACILITY	1
TOTAL	67

TABLE VII

LOCAL OMBUDSMAN PROBLEM SOLVING/COMPLAINT RESPONSE
RESIDENTIAL CARE FACILITIES

	Volunteers	Staff	Total
RESIDENT SERVICES	2	5	7
FOOD	8	16	24
RESIDENTS' RIGHTS	14	14	28
HOUSEKEEPING	2	1	3
ROOMMATE	16	2	18
ADMINISTRATION	0	1	1
BUILDING & OTHER	10	3	13
FINANCIAL	7	5	12
DISCRIMINATION	0	0	0
TOTAL	59	47	106

Of the 106 problems addressed at the local level during FY 1990, fifty-nine (59) were resolved by Ombudsman Volunteers. Another forty-seven (47) problems were addressed by the Supervisors.

Although Ombudsman problem-solving can be very successful in the Residential Care setting, it has been difficult to recruit volunteers to serve in these facilities. Historically, the majority of licensed Residential Care Homes serve chronically mentally ill adults or a younger developmentally disabled population. Few of these homes serve or specialize in services for the elderly only, although the number of such residential care facilities (sometimes called "assisted living" centers) is growing.

IV. FACILITIES WITH MULTIPLE COMPLAINTS

This Section describes only formal complaints received by the **State Health Department, DHS Long-Term Care Investigators** and **State Ombudsman** staff during Federal Fiscal Year 1990 (October 1, 1989 through September 30, 1990). The number of facilities named in three or more verified or partially verified complaints dropped again in FY 90 to a total of **13** nursing homes and one (1) Residential Care Home. A total of **125** complaints were lodged against these **13** nursing facilities, representing **17%** of all formal complaints filed with State agencies. In FY 1989, 21 facilities were listed.

Please note: This section does not describe problems resolved by Ombudsman Volunteers or staff or the problems and deficiencies found on routine and annual inspections. The willingness of facility staff to work with residents and families to solve problems within the facility significantly reduces the likelihood of formal complaints being filed. Current inspection reports are available for public review at the nursing facility.

Complaints were **not** included in this listing if the facilities worked with Ombudsman staff to resolve the problems **without** involvement of enforcement agencies.

The following facilities were the subject of three (3) or more verified or partially verified complaints. Narrative information follows on four (4) facilities with five (5) or more verified complaints that were still problems at the time of investigation. They are marked with an asterisk (*):

Bethany Village Nursing Home	Bethany
Bryant Nursing Center	Edmond
Checotah Manor Nursing Home	Checotah
Eastview Nursing Home	Enid
Edmond Nursing Center	Edmond
*Galilean Center (AA)	Anadarko
*Midwest City Nursing Center	Midwest City
Pekrul Christian Manor	Enid
*Prestige Manor Nursing Center	Okeene
Putnam City Convalescent Center	Bethany
Southern Oaks Nursing Home	Oklahoma City
*Walnut Creek Nursing Home	Oklahoma City
Westlake Nursing Center	Oklahoma City
Highland Residential Care Facility	Noble

If "adverse action" was taken against a listed home the symbol (**AA**) appears beside the name. Please refer to Appendix C.

The Galilean Center, Anadarko

All five formal complaints filed against the Galilean Center were totally or partially verified by investigators. An allegation of insufficient staff was verified in October of 1989. Although the minimum licensure ratios were met, a deficiency was cited by State Health Department under the Title XIX standards. They found insufficient numbers of staff to adequately address client programming and attend to behavior problems, personal care and transportation needs. Training programs were found not always adequate. Some programs were not fully in place. Not all behavioral needs had been addressed or behavioral plans for residents developed and reviewed.

In November, 1989, investigators verified poor housekeeping in some areas. The bathrooms on two halls were found to be "filthy, and the odor so bad the investigators could not go in. BM and urine were smeared on the floors. Water was standing where spilled. Dirty clothing and washcloths were left on the floors." Roaches were also seen in one of the bathrooms.

In January, 1990, an allegation was verified of medical neglect related to staff failure to report a significant change of condition, behavior and complaints of pain by a resident to his physician in a timely manner.

In April, an allegation of three residents with fractures was verified, and the injuries seemed to the investigator "to be the result of poorly trained, poorly organized staff and inadequate supervision of residents by staff." An allegation that one resident was brought back from the hospital in Oklahoma City without being properly clothed was also verified. Conditions in the facility were found to be disturbingly substandard with regard to housekeeping, maintenance, staffing and supervision, feeding practices, cleanliness, dressing and grooming of residents and lack of programming and meaningful activities.

In August, allegations concerning facility maintenance were verified. Beds were not made on one hall due to laundry problems and inadequate supply. Linens were found by the inspectors to be thin and dingy. Many windows had no screens in place. A deficiency was written with regard to pest control and not having screens on windows. An allegation concerning a missing glass panel adjacent to the front exterior door was also verified. The investigator observed staff and clients using this opening instead of the door. The panel had been missing and not repaired for several days. A deficiency relating to maintenance of the facility was written. Another deficiency was written concerning housekeeping, due to findings of spilled food left on the dining room floor and tables at mid-morning. A follow-up inspection was scheduled.

Problems continued in this facility into the current fiscal year resulting in monetary penalty to the facility and in the placement of a receiver by the State Department of Health to take over management and correct problems. This facility was also subject to penalty based on non-compliance with standards. (See Appendix C)

MIDWEST CITY NURSING CENTER, Midwest City

Eight of the thirteen formal complaints filed were verified during the reporting period at Midwest City Nursing Center. One complaint concerned a discrepancy between recorded and actual amount present of one narcotic. One allegation was that the staff borrowed diapers from one resident to use on others and never replaced them resulting in the family being charged for too many diapers. The investigator verified that the resident's diaper supply was depleted too quickly. Another verified complaint involved problems with food temperatures. Meals served from kitchen steam tables were inadequate to meet minimum licensure requirements. A deficiency was written.

In May, an investigator found no food available for second helpings of a meal, except for those residents who had double portions ordered. The investigator also found problems with food temperatures in the facility.

In June, food service was the subject of another complaint. The investigator verified that food was cold when it reached the residents. Residents stated they had to wait too long to get their meals. Dietary staff didn't note likes and dislikes of food items on the menu. Residents returned food and requested something different. Menus were not followed and there was no portion control. A new serving program was implemented which caused total confusion. Five people were ordering 2-3 trays each (aides for residents, staff for themselves and dietary staff for the dining room). According to the investigator, while serving the dining room residents, the dietary staff became so frustrated they stopped serving the food. A deficiency was written related to dietary services.

Another allegation of problems with timely medication administration was partially verified by the investigator because residents who had to take medications with their meals were delayed in doing so due to the length of time it took for meal service. Residents complained that it took a long time for nursing staff to assist them because they didn't have enough help, even though the facility met the minimum licensure requirement for staffing.

Another June 1990 complaint referred to residents not getting baths as scheduled. Bath and shower records were reviewed by the investigator. This investigator verified that on two halls,

residents were not given baths or showers as required. There were residents who had no bath or shower at all during the month of June, while others had only one bath or shower. A deficiency was written for not following bath schedules and lack of bathing.

Still another verified complaint in August involved poor food service, including not enough staff to assist residents and residents not receiving food in a timely manner. The investigation found food service to be slow. One resident sat with her food tray in front of her for 35 minutes until a nurse aide fed her. Several other residents were also left waiting for some time. A deficiency was cited. One dietary employee was observed placing numerous plates of uncovered food on the open metal food cart. Twenty residents in the large dining room stated their food was cold and the inspector observed that margarine would not melt on the vegetable. A deficiency was cited. Meal percentages were not documented. One resident needed assistance in cutting her food, and the investigator observed that there were no available employees to notice the situation. Other problems with food service were found. The supper meal was not distributed or served under sanitary conditions because there were numerous flies noted throughout the kitchen and main dining room. Flies were observed on the residents, their food trays and their water glasses. A deficiency was cited. An allegation of stale cigarette smoke lingering in the feeding room was also verified. A deficiency was cited.

Prestige Manor, Okeene

Five of ten formal complaints lodged against Prestige Manor were verified or partially verified during investigations at the facility.

One complaint investigation in December, 1989, revealed insufficient numbers of staff to feed residents on the evening shift and trays being transported down the hall to a dining room uncovered which resulted in cold food being delivered to residents to eat.

Another complaint alleging general neglect was partially verified in January. Numerous problems were found by investigators. These included weight loss with no evidence of supplements offered or given, not having a physical therapist or PT aide, and the administrator being unavailable to residents and families. Although there were activities planned, none were ever seen in progress by the investigator. The investigator concluded that more direct care staff were needed due to residents on the north hall needing assistance with feeding, positioning and body alignment, assistance with dressing and more frequent checks for those who were incontinent.

In June, a complaint was verified by the investigator due to the facility having no hot water in the laundry, resulting in skin rashes on residents apparently caused by bleach in the linens. A deficiency was cited for an inadequate maintenance program.

Another complaint investigation relating to an allegation of failure to provide adequate nursing care was conducted in July, in conjunction with a follow up investigation. The investigator found problems still remained related to record keeping, including omissions in medication and treatment sheets, personnel training and orientation records incomplete (including blank forms already signed by the employee), and nursing notes lacking pertinent information. The investigators concluded that the administrator was not available and staff supervision was inadequate. An assistant administrator had been hired. Other problems related to documentation of turning residents were also identified. Numerous rooms were found with no water pitchers or water glasses.

In August of 1990, a complaint alleging neglect by staff was investigated. Findings showed a lack of documentation in nursing notes and treatment sheets indicating no action was taken to prevent skin breakdown and treatment was delayed. Investigators found no doctors orders or documentation for certain treatments. A random review of nursing records indicated a lack of information for a thorough understanding of the residents' overall status. Investigators found call lights not accessible to a few residents, nursing documentation inadequate, and the administrator not available.

Problems were still being monitored and follow up investigations planned at the close of the fiscal year.

Walnut Creek Nursing Home, Oklahoma City

Six of thirteen formal complaints were verified at Walnut Creek Nursing Home. One complaint including allegations of poor nursing care and poor housekeeping was found to be partially verified in January, 1990. The facility was found in a state of disarray, with most residents appearing dirty, dishevelled and unkempt. The floors were dirty and in need of sweeping and mopping. "Bedside tables were dirty with snacks, juices, and milk that were warm and had obviously been there over an hour." Bedside commodes and bathrooms were dirty. An allegation of dirty laundry everywhere in the laundry room was verified. There were bundles and stacks of dirty and clean linens mixed together. Bedside call cords were not within reach of residents.

Numerous residents did not have water pitchers. Pitchers that were in place did not contain fresh ice and water or were empty. An allegation of the whirlpool not working was also verified. Another January complaint was verified concerning call lights not in reach of residents and water not in reach and/or not offered to bedfast and chairfast residents. Some water pitchers had no covers.

In May, 1990, allegations of urine on floors in resident and toilet rooms were verified by the State Health Department. Strong urine odors were present on one hall and in several rooms. Another allegation that families were not notified of residents receiving hepatitis shots was verified. The Oklahoma City-County Health Department had recommended that all residents get shots because an employee in the dietary department had hepatitis; the facility had followed the recommendations, but had not made proper notification. A second verified complaint in May also concerned urine odors in the facility.

Another partially verified complaint related to poor equipment. A plastic seat on a shower chair had broken causing injury to a resident. The investigator examined wheelchairs and shower chairs and found that two shower chairs needed new backs and the plastic seat of one of the whirlpool chairs was cracking again. The inspector recommended that these be repaired.

A complaint in June concerned bath care. The investigator found, through review of 67 resident records, that documentation was inconsistent and/or incomplete. There were blanks in the records from four to fourteen consecutive days in June. A deficiency was cited. Another partially verified allegation concerned poor food service. The investigator found that meal percentages were not documented. The meal service did not run smoothly. Two residents didn't receive their lunch trays until 1:00 pm. The facility did not have identification cards on two special diets and the staff person had trouble finding to whom the trays belonged. One hot food cart arrived at 1:00 pm. The doors to the food cart were left open, which allowed the food to cool. However, the investigators did observe that the food looked good and was well-received by the residents.

V. ISSUE: GUARDIANSHIPS and other Surrogate Decision-Making

The rights of long-term care facility residents to independent decision-making and knowledge of available choices for treatment have long been established in State and Federal laws pertaining to nursing homes. Issues with which Ombudsmen and others frequently grapple include: family and physician involvement in placement and care decisions, staff-directed treatment decisions, residents' "compliance" or "non-compliance" with doctor's orders, and the questionable or inconsistent capacity of some residents to participate in care-related decisions.

While these issues, when presented as concerns, often respond to fairly informal interventions (including sharing information on residents rights or negotiating with facilities or families), other situations require residents to obtain legal representation in order to obtain resolution. Historically, nursing homes have commonly given authority for decisions ranging from initial placement to visitation rights to Do Not Resuscitate orders to persons identified as the resident's "responsible party." The "responsible party" was permitted by nursing home law and originally intended to be a third-party guarantor of payment or simply an emergency contact. As a result of widespread misunderstanding or misuse, nursing home residents and their advocates have had to struggle against facility policies like those stating: "The resident cannot be discharged except by the person (responsible party) who checked him/her in." This type of rights violation was more widespread prior to OBRA 1987 federal nursing home reforms, which gave intense scrutiny to Residents Rights issues.

During the reporting period, Ombudsman involvement with residents rights issues related to guardianship increased significantly. Most facilities now understand that a person cannot be placed in a nursing home against his/her will unless a court has authorized someone to make such decisions for the individual. Likewise, residents cannot be forced to remain in a facility once placed, nor to accept care. Ombudsman staff have worked with clients who wish to return home, or who desire to change other aspects of their circumstances (control their own checking accounts, change nursing homes, select their own companions), but are restricted by family members or others.

In some cases, movement toward increased independence by the resident motivates family members to petition for guardianship "for the resident's protection" or for the family's convenience. In these situations, the resident may acquiesce in order to avoid alienating relatives. When the resident does decide to resist the taking of a guardianship over her, however, she may face a myriad of problems.

First, not all prospective wards even receive notice of guardianship actions against them, even though Oklahoma's new guardianship statute requires such notice. Another serious problem for the elder is acquiring legal representation. Residents with ample financial resources, but no access to those resources, have had to rely on public defenders or Legal Aid for representation.

State law provides that a prospective ward must be provided with legal counsel, if appropriate. But public defenders often are overloaded with criminal cases, and ill-prepared to represent elderly persons who have capacity for personal autonomy, but whose lives may be complicated by physical problems or gaps in community resources for supportive services. Special training for public defenders would be helpful.

Legal Aid has assisted elders resisting guardianship or seeking to have a guardianship rescinded or limited, but a need also exists for attorneys to represent nursing home residents on a pro bono basis. Younger institutionalized individuals, not only elders, face similar needs for representation.

Some elders, of course, do need assistance in managing their daily lives, making care and treatment decisions, and/or transacting their business affairs. Oklahoma lacks programs designed to provide "guardianship diversion" services, such as those piloted in other areas of the United States. Such programs may provide case management services, or use trained volunteers who provide specific services, such as balancing the check book or assisting in bill-paying for individuals who need such support but not full guardianship. Other programs utilize multidisciplinary panels of legal, health care and social work professionals who review court-referred cases prior to court hearings, and recommend guardianship alternatives to the court.

In some cases a guardian may be needed, and a relative or friend may be willing to serve, but neither prospective ward nor guardian has the financial resources to pursue the legal appointment. In many other cases, the elder has no relative or other close person available to take the responsibility (sometmes due simply to outliving his or her "support system".)

Oklahoma lacks a Public Guardian program, the need for which has been identified and documented by a variety of groups. Most notably, a 1989 Interim Task Force of the Oklahoma Legislature recommended that the State establish an Office of Public Guardian in the (Oklahoma) Supreme Court Administrator's Office or the Attorney General's office to address this unmet need. Underscoring the need for a structured program of public guardianship, is the lack of success of two State agencies in finding volunteer guardians for clients in need of such protection.

Frail elders are living longer. Such individuals' circumstances often create the need for clear decision-making authority related to care and treatment, as well as business transactions. The public needs information about preparing in advance for possible losses of capacity, and how to take advantage of less costly and less invasive options, such as Power of Attorney and Durable Power of Attorney. In addition, lawyers and judges both need expanded training in the use of the new Guardianship statute to help them understand the range of creative options now possible in crafting limited guardianships in Oklahoma, and to appreciate more fully the importance of this approach to elders' needs and rights.

VI. APPENDICES

APPENDIX A

OMBUDSMAN PROGRAM FUNDING
STATE OF OKLAHOMA FY 1990

State Level Program	Source	Amount of Funding	Staffing
Long-Term Care Ombudsman Program Aging Services Division Department of Human Services Post Office Box 25352 Oklahoma City, Oklahoma 73125 (405) 521-6734	Title III Federal State TOTAL	 36,877 65,358 102,235	1 State Ombudsman 1 Omb.Prog. Coordinator 1 Admin. Assistant
Sub-State Programs			
1. Long-Term Care Ombudsman Program Grand Gateway Area Agency/Aging Post Office Box 330 Vinita, Oklahoma 74301 (918) 256-6478 or 1-800-482-4594	Federal State Local TOTAL	8,236 14,742 0 22,978	1 Supervisor 8 Volunteers
2. Long-Term Care Ombudsman Program EODD Area Agency on Aging Post Office Box 1367 Muskogee, Oklahoma 74402 (918) 682-7891	Federal State Local	34,712 8,896 0 43,608	1 Supervisor 7 Volunteers
3. Long-Term Care Ombudsman Program KEDDO Area Agency on Aging Post Office Box 638 Wilburton, Oklahoma 74578 (918) 465-2367 or 1-800-722-8180	Federal State Local TOTAL	17,282 15,095 3,233 35,610	1 Supervisor 9 Volunteers
4. Long-Term Care Ombudsman Program SODA Area Agency on Aging Post Office Box 848 Ardmore, Oklahoma 73401 (405) 226-2250 or 1-800-522-3780	Federal State Local TOTAL	13,339 7,000 0 20,339	1 Supervisor 16 Volunteers
5. Long-Term Care Ombudsman Program COEDD Area Agency on Aging 400 North Bell Shawnee, Oklahoma 74801 (405) 273-6410 or 1-800-375-8255	Federal State Local TOTAL	33,400 2,949 2,948 39,297	1 Supervisor 15 Volunteers

Sub-State Programs	Source	Amount of Funding	Staffing
6. Long-Term Care Ombudsman Program Tulsa Area Agency on Aging 130 N. Greenwood, Suite 5 Tulsa, Oklahoma 74120 (918) 596-7688	Federal State Local TOTAL	27,971 5,418 2,082 35,471	2 Supervisors 33 Volunteers
7. Long-Term Care Ombudsman Program NODA Area Agency on Aging 1216 West Willow, Suite "A" Enid, Oklahoma 73703 (405) 237-2205	Federal State Local TOTAL	19,413 6,833 6,832 33,078	1 Supervisor 32 Volunteers
8. Long-Term Care Ombudsman Program Areawide Aging Agency, Inc. 3200 N.W. 48th, Suite 104 Oklahoma City, Oklahoma 73112 (405) 942-8500	Federal State Local TOTAL	48,898 5,404 5,404 59,706	2 Supervisors 44 Volunteers
9. Long-Term Care Ombudsman Program ASCOG Area Agency on Aging Post Office Box 1647 Duncan, Oklahoma 73533 (405) 252-0595 or 1-800-658-1466	Federal State Local TOTAL	35,118 2,562 0 37,680	1 Supervisor 18 Volunteers
10. Long-Term Care Ombudsman Program SWODA Area Agency on Aging Post Office Box 569 Burns Flat, Oklahoma 73624 (405) 562-4884	Federal State Local TOTAL	22,790 4,021 6,196 33,007	1 Supervisor 24 Volunteers
11. Long-Term Care Ombudsman Program OEDA Area Agency on Aging Post Office Box 668 Beaver, Oklahoma 73932 (405) 625-4531 or 1-800-658-2844	Federal State Local TOTAL	20,025 16,084 3,835 39,944	1 Supervisor 30 Volunteers

State and Sub-State	
Federal	318,061
State	154,362
Local	30,530
TOTAL	502,953

APPENDIX B

Types of Long-Term Care Facilities in Oklahoma

The Long-Term Care Ombudsman Program in Oklahoma directs its attention and efforts toward improved life quality and living conditions for older residents of the State's "long-term care facilities." The phrase "long-term care facilities" refers to all kinds of facilities, except mental hospitals, that provide nursing, custodial or other personal care assistance to older persons in Oklahoma. These include nursing facilities, residential care facilities, and other similar adult care homes. Following are definitions and descriptions of services which may help to identify the various types of facilities.

Residential Care Facilities

As defined by Oklahoma's 1987 Residential Care Act, Residential Care Home means any establishment or institution other than a hotel, motel, fraternity or sorority house or college or university dormitory which offers or provides residential accommodations, food service, and supportive assistance to any of its residents or houses any residents requiring supportive assistance who are not related to the owner or administrator of the home by blood or marriage. Said residents shall be ambulatory and essentially capable of managing their own affairs, but do not routinely require skilled nursing care or intermediate nursing care. A residential care home may consist of a series of units or buildings which are not connected or part of the same structure if they meet certain other conditions (See Residential Care Act 63 O.S. Sections 1-820).

"Supportive assistance" means the service rendered to any person which is sufficient to enable the person to meet an adequate level of daily living. Supportive assistance includes but is not limited to housekeeping, assistance in the preparation of meals, assistance in the safe storage, distribution and administration of medications and assistance in personal care as is necessary for the health and comfort of such persons. Supportive Assistance shall not include medical services. Under state law, Residential Care Facilities must be licensed by the State Department of Health and are periodically inspected.

NURSING FACILITIES

Since the close of the fiscal year the distinction between intermediate and skilled nursing facilities has been eliminated.

"Nursing facility" means a home, an establishment or an institution a distinct part thereof which is primarily engaged in providing:

a. skilled nursing care and related services for residents who require medical or nursing care.

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

c. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services beyond the level of care provided by a residential care home which can be made available to them only through a nursing facility;

APPENDIX C

ADVERSE ACTION LIST FY 1990

This list reflects adverse actions relating to Licensure and/or Medicaid Certification, initiated by the Oklahoma State Health Department and the Department of Human Services. Adverse Actions related to Medicaid Certification resulted in financial penalties against the facilities. The amount of money shown was withheld by DHS from the facilities' Medicaid reimbursement for the period of non-compliance (minimum of 5 days, at $5.00 per Medicaid resident per day).

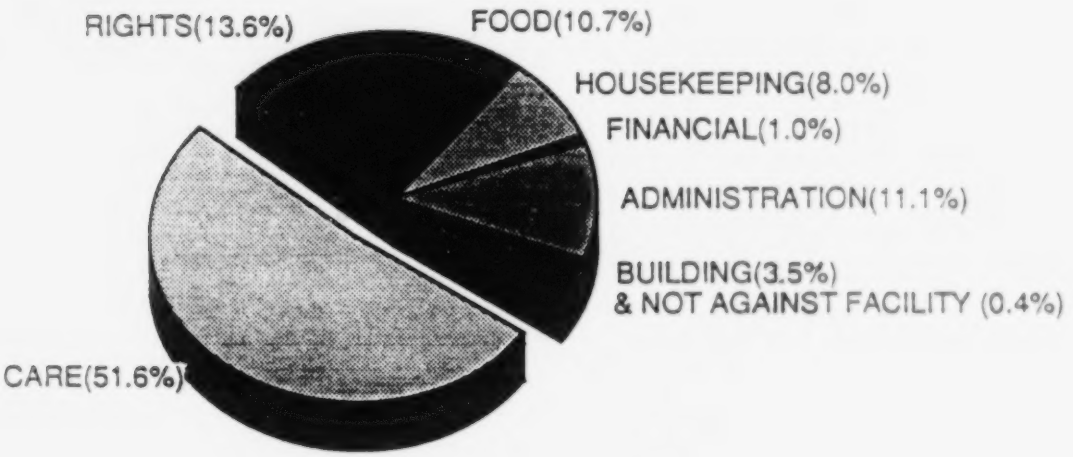
FACILITY	ACTION	DATE NOTIFIED	MONEY PENALTY
*The Galilean Center, Anadarko	Medicaid	10-02-89	$ 4,625
Morning Star, Oklahoma City	Medicaid	10-12-89	$ 1,050
Coweta Manor, Coweta	Medicaid	11-23-89	$ 4,215
Edwards Redeemer, Oklahoma City	Medicaid	12-26-89	$ **0
*Cottonwood Manor, Yukon	Medicaid	3-20-90	$ 2,650
Park Terrace Convalescent Ctr. Tulsa, OK	Medicaid	4-19-90	$ 922
Colonial Manor II, Hollis	Medicaid	5-14-90	$ 2,565
Colonial Nursing & Retirement Center, Pauls Valley	Medicaid	8-01-90	$ 1,890
Prairie View Manor, Clinton	Medicaid	9-21-90	$ 675
		Money Penalties TOTAL	$18,592

* Intermediate Care Facilities for the Mentally Retarded
** Not penalized due to bankruptcy

APPENDIX D

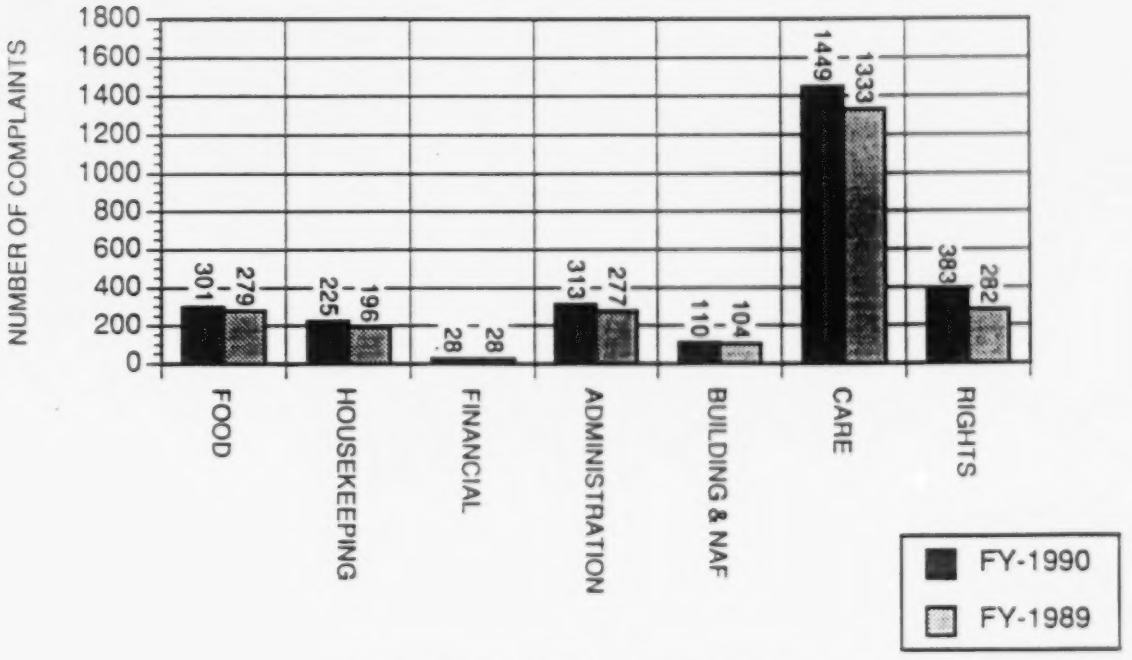
NURSING HOME COMPLAINTS BY CATEGORIES

Graph 1: FFY-1990: Total Allegations 2809



COMPARISON OF 1989 AND 1990 NURSING HOME COMPLAINTS BY CATEGORIES

Graph 2: FFY-1989-90



TOTAL COMPLAINTS FOR FFY-90: 2809

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